Mail your completed order form, original prescription(s) and payment to: **NextRx, PO Box 746000, Cincinnati, OH 45274-6000.**

If you have multiple prescriptions, include all prescriptions with the order form. You may duplicate the order form as needed.

nextRx SM

## Section 1: Member Information

Provide policy or cardholder information as found on the health plan or benefit card. Please do not write on the back of form.

Name of Your Health Plan

Identification Number

Policy or cardholder last name

First name

Initial

Date of birth (MM/DD/YYYY) / /

## Section 2: Shipping Information

Orders ship within seven days of receipt of valid order. Controlled and refrigerated medications cannot ship to a PO box. Schedule II controlled substances require signature on delivery.

New address ☐ Y ☐ N

Street address

Apartment/suite

City

State

ZIP code

Daytime phone # (including area code)

E-mail address

Evening phone # (including area code)

## Section 3: Payment Information

Payment is required before an order will ship. Do not send cash. Make checks and money orders payable to NextRx. There is a $25 fee for returned checks. Credit cards are charged for the entire order and used for future orders unless a new payment method is specified. Rush shipping does not expedite prescription processing time.

Payment method: ☐ Check ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ Overnight Shipping (add $20)

Account number

Expiration date

Signature/date

Amount enclosed:

Coupon Code:

☐ Please place prescription(s) on file for later. Do not dispense at this time.

## Section 4: Prescription Information

Federally approved, generic-equivalent medications will be dispensed for brand name medications unless otherwise directed by the patient, physician, or health plan.

Patient last name

First name

Initial

Patient date of birth (MM/DD/YYYY) / /

Patient gender ☐ M ☐ F

Drug allergies (check all that apply): ☐ Penicillin ☐ Aspirin ☐ Codeine ☐ Sulfa

☐ Other (list all, including over-the-counter medications)

Medical history (check all that apply): ☐ Diabetes ☐ Glaucoma ☐ High blood pressure ☐ Arthritis

☐ Thyroid ☐ Heart condition ☐ Asthma ☐ Other (list all)

| New prescription: medication name | Doctor last name | Taken before | |
|---|---|---|---|
| | | ☐ Y ☐ N | ☐ Check corresponding box to place prescription(s) on file for later fill. Do NOT dispense at this time. |
| | | ☐ Y ☐ N | |
| | | ☐ Y ☐ N | |

| Refill orders: Rx refill # | Medication name |
|---|---|
| | |
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